

SECTION 3- INFORMATION ABOUT YOUR MEDICAL RECORDS, continued

HOSPITAL/CLINIC

2. NAME			PHONE () - (area code) (phone number)	
ADDRESS			PATIENT ID # (if known)	NEXT APPOINTMENT
CITY	STATE	ZIP	What doctor(s) do you regularly see here?	

TYPE OF VISIT	DATES (within the last 12 months)		REASON FOR VISIT(S)	TREATMENT RECEIVED
	Date In	Date Out		
Inpatient Stays (stayed at least overnight)				
Outpatient Visits (sent home the same day)	First Visit	Last Visit	REASON FOR VISIT(S)	TREATMENT RECEIVED
Emergency Room Visits	Date(s) of Visit(s)		REASON FOR VISIT(S)	TREATMENT RECEIVED

3. NAME			PHONE () - (area code) (phone number)	
ADDRESS			PATIENT ID # (if known)	NEXT APPOINTMENT
CITY	STATE	ZIP	What doctor(s) do you regularly see here?	

TYPE OF VISIT	DATES (within the last 12 months)		REASON FOR VISIT(S)	TREATMENT RECEIVED
	Date In	Date Out		
Inpatient Stays (stayed at least overnight)				
Outpatient Visits (sent home the same day)	First Visit	Last Visit	REASON FOR VISIT(S)	TREATMENT RECEIVED
Emergency Room Visits	Date(s) of Visit(s)		REASON FOR VISIT(S)	TREATMENT RECEIVED

If you need more space, use SECTION 10 - REMARKS.